

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W 0000 Bldg. 00	<p>This visit was for the Post Certification Revisit (PCR) to the extended recertification and state licensure survey completed on 8/5/15.</p> <p>This visit was in conjunction with the investigation of complaint #IN00179719.</p> <p>Survey Dates: September 17, 18 and 21, 2015</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/28/15.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 4 of 4 clients living in the group home (A, B, C and D) and one additional client (E), the facility failed to meet the Condition of Participation: Governing</p>	W 0102	In the absence of a Team Manager assigned to the home, the Director of	10/21/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Body. The facility's governing body failed to exercise operating direction over the facility by failing to implement the Plan of Correction, as indicated, for the recertification and state licensure survey completed on 8/5/15. The governing body failed to ensure observations were conducted on a daily basis at the group home by administrative staff for 4 weeks. The governing body failed to ensure the Team Manager documented when she worked alongside staff to provide ongoing monitoring and support. The governing body failed to ensure the Network Director conducted visits to the group home no less than twice weekly. The governing body failed to ensure mealtime observations were conducted 4 times per week for 4 weeks. The governing body failed to prevent client D from eloping from the group home on consecutive days, conduct thorough investigations and take appropriate corrective actions to address client D's elopement. The governing body to ensure staff was deployed appropriately to prevent elopement.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 4 of 4 clients living in the group home (A, B, C and D) and one additional client (E), the facility's governing body failed to</p>		<p>Residential Services and the Network Director/ QDDP have been in the home several times per week to ensure implementation of all individual plans as written. A shared master observation calendar is now in place, and supervisory staff, including the DRS, ND/QDDP, Director of Support Services and Chief Services Officer have been completing observations daily. Daily observations will continue until 11/2/15, at which time the Services Leadership Team will determine the necessity for daily observations to continue. On an ongoing basis, the</p>				

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	<p>exercise operating direction over the facility by failing to implement the Plan of Correction, as indicated, for the recertification and state licensure survey completed on 8/5/15. The governing body failed to ensure observations were conducted on a daily basis at the group home by administrative staff for 4 weeks. The governing body failed to ensure the Team Manager documented when she worked alongside staff to provide ongoing monitoring and support. The governing body failed to ensure the Network Director conducted visits to the group home no less than twice weekly. The governing body failed to ensure mealtime observations were conducted 4 times per week for 4 weeks.</p> <p>2) Please refer to W122. For 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to prevent client D from eloping from the group home on consecutive days, conduct thorough investigations and take appropriate corrective actions to address client D's elopement.</p> <p>9-3-1(a)</p>		<p>ND/QDDP will be in the setting no less than twice weekly, and the DRS no less than monthly, to ensure all plans are implemented as written and concerns are addressed. Additionally, the staff meet with the ND/QDDP twice monthly to discuss customer concerns, address staff training issues, etc. Investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to</p>				

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			include elopement, and all staff will be trained on the updated plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until		

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 4 of 4 clients living in the group home (A, B, C and D) and one additional client (E), the facility's governing body failed to exercise operating direction over the facility by failing to implement the Plan of Correction, as indicated, for the recertification and state licensure survey completed on 8/5/15. The governing body failed to ensure observations were conducted on a daily basis at the group	W 0104	follow up is completed. The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed. In the absence of a Team Manager assigned to the home, the Director of Residential Services and the Network Director/ QDDP have been in the home several times per week	10/21/2015

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	<p>home by administrative staff for 4 weeks. The governing body failed to ensure the Team Manager documented when she worked alongside staff to provide ongoing monitoring and support. The governing body failed to ensure the Network Director conducted visits to the group home no less than twice weekly. The governing body failed to ensure mealtime observations were conducted 4 times per week for 4 weeks. The governing body to ensure staff was deployed appropriately to prevent elopement.</p> <p>Findings include:</p> <p>On 9/17/15 at 11:43 AM, a review of the facility's Plan of Correction (POC), with a completion date of 9/4/15, indicated for W104, "The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director (ND)/QDDP (Qualified Developmental Disabilities Professional) is in the home no less than twice weekly...."</p> <p>For W154, the POC indicated, in part, "The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director/QDDP is in the home no less than twice weekly...."</p>		<p>to ensure implementation of all individual plans as written. A shared master observation calendar is now in place, and supervisory staff, including the DRS, ND/QDDP, Director of Support Services and Chief Services Officer have been completing observations daily. Daily observations will continue until 11/2/15, at which time the Services Leadership Team will determine the necessity for daily observations to continue. On an ongoing basis, the ND/QDDP will be in the setting no less than twice weekly, and the DRS no less than monthly, to ensure all</p>				

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	<p>For W159, the POC indicated, in part, "Ongoing monitoring will be accomplished through the Team Manager, who works full time in the home alongside staff to provide ongoing modeling and support. The Network Director, Director of Residential Services, Director of Support Services and Chief Services Officer will complete daily observations for a period of no less than 4 weeks to ensure staff are implementing plans as written, and the ND/QDDP will be in the home no less than twice weekly on an ongoing basis...."</p> <p>For W249, the POC indicated, in part, "Ongoing monitoring will be accomplished through the Team Manager, who works full time in the home alongside staff to provide ongoing modeling and support. The Network Director/QDDP, Director of Residential Services, Director of Support Services and Chief Services Officer will complete daily observations for a period of no less than 4 weeks to ensure staff are implementing plans as written, and the ND/QDDP will be in the home no less than twice weekly on an ongoing basis...."</p> <p>For W289, the POC indicated, in part,</p>		<p>plans are implemented as written and concerns are addressed. Additionally, the staff meet with the ND/QDDP twice monthly to discuss customer concerns, address staff training issues, etc.</p>		

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	<p>"Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director/QDDP is in the home no less than twice weekly...."</p> <p>For W460, the POC indicated, in part, "Monitoring will be accomplished through observations, including mealtime observations, by the ND/QDDP, Director of Residential Services (DORS), Quality Assurance Director (QAD), and Director of Support Services (DOSS) 4 times per week for a period of 4 weeks. On an ongoing basis, the ND/QDDP will observe staff in the setting no less than twice weekly. Additionally, the Team Manager (TM) is assigned to the home full time, and works alongside direct support staff, providing ongoing support, supervision and training as needed."</p> <p>For W488, the POC indicated, in part, "Ongoing monitoring will be accomplished through regular and frequent mealtime observations. The ND/QDDP, Director of Residential Services, Quality Assurance Director and Director of Support Services will conduct mealtime observations at least 4 times per week for a period of at least 4 weeks. The TM works full time in the home alongside direct support staff and is there</p>			

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	<p>during mealtime several times per week to provide modeling and training on an ongoing basis."</p> <p>The facility did not have a Team Manager at the time of the follow-up survey. There was no documentation provided indicating when the Team Manager worked in the setting alongside staff to provide ongoing monitoring and support. There was no documentation of the ND conducting visits to the group home no less than twice weekly. There was no documentation the Network Director, Director of Residential Services, Director of Support Services and Chief Services Officer completed daily observations for a period of no less than 4 weeks to ensure staff implemented the clients' plans as written. There was no documentation the facility conducted mealtime observations. On 9/18/15 at 3:02 PM, the Director of Support Services submitted, by email, one documented observation she conducted for the POC on 9/1/15 from 4:15 PM to 5:00 PM.</p> <p>On 9/18/15 at 2:35 PM, the Human Resources Director indicated the former Quality Assurance Director's last day at the facility was on 8/14/15. The HRD indicated the former TM's last day was 8/30/15.</p>			

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	<p>On 9/18/15 at 3:53 PM, the ND indicated she did not have documentation of her observations at the group home. The ND indicated she conducted two observations and submitted her documentation to the DRS. The ND indicated the DRS was unable to locate the observations she conducted. The ND indicated the DRS was at the group home the most of the administrative staff. The ND indicated the DRS did not have documentation of the observations he conducted at the group home. The ND indicated she was unsure if the other administrative staff conducted observations at the group home.</p> <p>On 9/18/15 at 2:43 PM, the Director of Support Services (DOSS) indicated she conducted one observation. The DOSS indicated the DRS conducted a large portion of the observations. The DOSS indicated the administrative staff were to conduct daily observations for 4 weeks.</p> <p>On 9/18/15 at 2:52 PM, the Chief Services Officer (CSO) indicated she did not conduct any observations for the Plan of Correction. The CSO indicated the POC should have been implement as indicated in the plan. The CSO stated, when asked why she did not conduct observations for the POC, "I guess I was</p>			

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W 0122 Bldg. 00	<p>not told I was supposed to." The CSO indicated she thought the observation schedule was covered.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to prevent client D from eloping from the group home on consecutive days, conduct thorough investigations and take appropriate corrective actions to address client D's elopement. The facility failed to ensure staff was deployed appropriately to prevent client D from eloping.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 2 of 3 incident/investigative reports reviewed</p>	W 0122	To correct the deficient practice, investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to include elopement, and all staff will be trained on the updated	10/21/2015

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	<p>affecting client D, the facility neglected to implement its policies and procedures to prevent client D from eloping from the group home on consecutive days, conduct a thorough investigation and take appropriate corrective actions to address client D's elopement.</p> <p>2) Please refer to W154. For 2 of 3 incident/investigative reports reviewed affecting client D, the facility to conduct thorough investigations of two incidents of client D eloping from the group home on consecutive days.</p> <p>3) Please refer to W157. For 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to take appropriate corrective actions to address client D's elopement from the group home on consecutive days.</p> <p>4) Please refer to W186. For 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to provide sufficient staff to monitor and supervise the clients in accordance with their individual support plans.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until follow up is completed. The Services Leadership Team,</p>	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility neglected to implement its policies and procedures to prevent client D from eloping from the group home on consecutive days, conduct thorough investigations and take appropriate corrective actions to address client D's elopement incidents in a plan. The facility failed to ensure staff was deployed appropriately to prevent elopement.</p> <p>Findings include:</p>	W 0149	<p>which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p> <p>To correct the deficient practice, investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan</p>	10/21/2015

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	<p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident</p>		<p>will be revised to include elopement, and all staff will be trained on the updated plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on</p>		

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	<p>report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The facility failed to conduct an investigation into the incident of elopement. The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement. The facility failed to identify the incidents as potential neglect.</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through</p>		<p>an ongoing basis until follow up is completed. The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>	

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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	<p>the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to conduct an investigation into the incident of elopement. The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement. The facility failed to identify the incidents as potential neglect.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a</p>			

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	<p>targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the</p>			

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	<p>former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/17/15 at 3:59 PM, the Network Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the</p>			

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	<p>facility has door alarms. The ND indicated the staff was instructed to keep client D engaged in activities. The ND indicated additional staff was added to the schedule in the morning. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the facility did not conduct full investigations into the incidents. The DRS indicated full investigations should have been conducted. The DRS indicated the alarms were in use for a peer's elopement behavior but since the incidents the alarms were now in place for client D as well. The DRS indicated client D's plan should have been updated to indicate the alarms were in place for him. The DRS indicated elopement should have been included in client D's plan. On 9/21/15 at 11:01 AM, the DRS indicated he was unsure how many clients were at the group home at the time of the incidents.</p>			

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	<p>The DRS indicated the staff was not in position to prevent the incident on 8/4/15. The DRS indicated client D's elopement on 8/3/15 was the first time he had ever left the group home. The DRS indicated the clients required 24 hour supervision by the staff.</p> <p>On 9/17/15 at 12:43 PM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/ her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology." The facility's policy titled,</p>			

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	"Investigating suspected cases of violations of rights," indicated the purpose of the policy was to "To ensure thorough, timely investigations and appropriate review." The policy indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 10. Any staff member or consultant suspected of violating customer rights shall be			

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W 0154 Bldg. 00	<p>suspended pending completion of the investigation... 13. The investigation must be initiated within 24 hours of the initial report."</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility to conduct thorough investigations of two incidents of client D eloping from the group home on consecutive days.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident</p>	W 0154	To correct the deficient practice, investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to	10/21/2015

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	<p>report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The facility failed to conduct an investigation into the incident of elopement.</p>		<p>include elopement, and all staff will be trained on the updated plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until</p>	

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	<p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told</p>		<p>follow up is completed. The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>				

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	<p>them [client D] came back after 15 minutes."</p> <p>The facility failed to conduct an investigation into the incident of elopement.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go</p>			

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	<p>around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client</p>			

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W 0157 Bldg. 00	<p>D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the facility did not conduct full investigations into the incidents. The DRS indicated full investigations should have been conducted.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to take appropriate corrective</p>	W 0157	To correct the deficient practice, investigations have been completed	10/21/2015			

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	<p>actions to address client D's elopement from the group home on consecutive days.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's</p>		<p>for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to include elopement, and all staff will be trained on the updated plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor</p>				

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	<p>house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement.</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to</p>		<p>all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until follow up is completed. The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>	

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	<p>monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues</p>			

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	<p>of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the</p>			

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	<p>future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/17/15 at 3:59 PM, the Network Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the facility has door alarms. The ND indicated the staff was instructed to keep client D engaged in activities. The ND</p>			

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	<p>indicated additional staff was added to the schedule in the morning. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the alarms were in use for a peer's elopement behavior but since the incidents the alarms were now in place for client D as well. The DRS indicated client D's plan should have been updated to indicate the alarms were in place for him. The DRS indicated elopement should have been included in client D's plan.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W 0186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to provide sufficient staff to monitor and supervise the clients in accordance with their individual support plans.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident date and time was 8/3/15 at 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff</p>	W 0186	To correct the deficient practice and prevent it from recurring, the Network Director/ QDDP (ND/Q) will revise the Behavior Support Plans for all individuals living in the home. The ND/Q and Director of Residential Services (DRS) will review the staffing patterns in conjunction with the revised BSPs to ensure staff are deployed in accordance with the BSPs. All staff will be retrained on the revised plans and schedules, as well as	10/21/2015

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	<p>#5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was</p>		<p>who to contact should another staff fail to show up for a shift, to ensure that a replacement can be made available. Ongoing monitoring will be accomplished by the DRS review of staff schedules on an ongoing basis to ensure staff are maintained at the identified ratios.</p>	

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	<p>one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to ensure staff was deployed appropriately to prevent client D from eloping from the group home.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression,</p>			

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	<p>sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated she was unsure which clients were at the group home at the time of the incident but she indicated it was more than two clients. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D (and left the other clients unsupervised) and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client</p>			

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	<p>D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 indicated she was at the home by herself with clients D and E. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped</p>			

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	<p>and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/17/15 at 3:59 PM, the Network Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the facility has door alarms. The ND indicated the staff was instructed to keep client D engaged in activities. The ND indicated additional staff was added to the schedule in the morning following the incidents. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the facility did not conduct full investigations into the incidents. The DRS indicated full investigations should have been</p>			

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W 0262 Bldg. 00	<p>conducted. The DRS indicated the alarms were in use for a peer's elopement behavior but since the incidents the alarms were now in place for client D as well. The DRS indicated client D's plan should have been updated to indicate the alarms were in place for him. The DRS indicated elopement should have been included in client D's plan. On 9/21/15 at 11:01 AM, the DRS indicated he was unsure how many clients were at the group home at the time of the incidents. The DRS indicated the staff was not in position to prevent the incident on 8/4/15. The DRS indicated client D's elopement on 8/3/15 was the first time he had ever left the group home. The DRS indicated the clients required 24 hour supervision by the staff.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection</p>						

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	<p>and rights.</p> <p>Based on record review and interview for 1 of 3 non-sampled clients (E), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the client's restrictive Behavioral Support Plan (BSP).</p> <p>Findings include:</p> <p>On 9/17/15 at 12:13 PM, a review of the facility's plan of correction documentation was conducted. Client E transferred to another group home operated by the facility on 8/6/15. Client E's group home records were not available for review during the survey. The facility failed to provide documentation client E's BSP was reviewed, approved and monitored by the HRC. Client E's 8/1/14 BSP included the use of restraint for self-injurious behavior (SIB) and psychotropic medications (divalproex and Intuniv for tantrums/SIB). There was no documentation in client #5's record indicating the facility's HRC reviewed, approved and monitored the use of the restrictive BSP.</p> <p>On 9/17/15 at 12:16 PM, the Director of Residential Services (DRS) indicated he was attempting to locate the</p>	W 0262	<p>To correct the deficient practice, client E's BSP was reviewed by the guardian on 9/21/15, and by the HRC on 9/23/15. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures.</p> <p>Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory</p>	09/23/2015

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W 0263 Bldg. 00	<p>documentation. On 9/18/15 at 11:04 AM, the DRS indicated he was unable to locate documentation the HRC reviewed, approved and monitored client E's BSP.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 3 non-sampled clients (E), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure client E's restrictive program had written informed consent from the client's guardian.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:13 PM, a review of the facility's plan of correction documentation was conducted. Client E transferred to another group home operated by the facility on 8/6/15. Client E's group home records were not</p>	W 0263	<p>meetings to ensure all plans are current, with appropriate consents obtained.</p> <p>To correct the deficient practice, client E's BSP was reviewed by the guardian on 9/21/15, and by the HRC on 9/23/15. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC</p>	09/23/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/21/2015	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>available for review during the survey. The facility failed to provide documentation of written informed consent for client E's ISP. Client E's ISP, dated 8/1/14, included the use of psychotropic medications (Intuniv and Abilify - no purpose identified in the plan). Client E's 8/1/14 BSP included the use of restraint for self-injurious behavior (SIB) and psychotropic medications (divalproex and Intuniv for tantrums/SIB). There was no documentation provided for review indicating the facility obtained written informed consent from client E's guardian for the use of the restrictive BSP.</p> <p>On 9/17/15 at 12:16 PM, the Director of Residential Services (DRS) indicated he was attempting to locate the documentation. On 9/18/15 at 11:04 AM, the DRS indicated he was unable to locate documentation client E's guardian gave written informed consent for his ISP and BSP.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.</p>				

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W 0312 Bldg. 00	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure client A's Behavioral Support Plan (BSP) included a medication reduction plan for his psychotropic medications.</p> <p>Findings include:</p> <p>On 9/17/15 at 1:11 PM, a review of client A's record was conducted. Client A's BSP, dated 8/6/15, indicated he was prescribed the following psychotropic medications: Sertraline (depression/anxiety), Ziprasidone (bi-polar disorder) and Methylphenidate (Attention Deficit Hyperactivity Disorder). The section for Targeted Behavior Frequency for Reduction section indicated the following for each medication, "Will be determined once baseline data is obtained." There was no plan in place to reduce the use of client A's psychotropic medications.</p>	W 0312	Client A was admitted to the group home in June 2015 from his family home and lacked baseline behavioral data needed to create a sufficient medication reduction plan. 3 months of behavioral data has now been collected, and client A is established with a local psychiatrist. The ND/Q will develop a medication reduction plan for client A. All ND/Qs have been retrained on the necessity of medication reduction plans for psychotropic medications. Ongoing monitoring will be accomplished through the review of all BSPs by either the Director of Residential Services or agency Behavior Specialist to ensure all required elements are included.	10/21/2015

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W 9999 Bldg. 00	<p>On 9/17/15 at 3:34 PM, the Network Director (ND) indicated the facility had enough data for a baseline. The ND indicated client A's BSP should have a psychotropic medication reduction plan.</p> <p>This deficiency was cited on 8/5/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p>	W 9999	No deficiencies cited for this tag	10/10/2015	